DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G215	A. BUILDING _____ B. WING _____	01/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCI-TRIANGLE HOUSE I	1406 TYONEK DRIVE DURHAM, NC 27703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.	E 039	A full- scale community based or individual facility-based exercise or a table top exercise will be completed within the next 45 days to test the emergency plan. The facility response will be documented and analyzed for continued best practice in the event of an emergency. Any identified needed revisions will be completed with a focus on maximizing the effectiveness of the emergency plan during a true crisis. The Director and assigned facility Executive Director will monitor at least every 9 months to assure that appropriate planning is being conducted to assure that the full-scale and/or table top exercise will be completed within the appropriate timeline-annually RECEIVED JAN 31 2019 DHSR-MH Licensure Sect	3-17-19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Chief Operations Office | 1-30-2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G215	A. BUILDING _____ B. WING _____	01/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCI-TRIANGLE HOUSE I	1406 TYONEK DRIVE DURHAM, NC 27703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 1 *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure a facility/community-based or tabletop exercise was conducted to test their emergency plan. The finding is: The facility's Emergency Preparedness (EP) plan did not include completion of facility/community-based exercise or tabletop exercise. Review on 1/14/19 of the facility's EP plan (dated 2018) did not include a full-scale community-based or individual facility-based exercise or a tabletop exercise to test their emergency plan. Interview on 1/15/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the facility has not conducted a full-scale facility/community-based exercise or a tabletop	E 039		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G215	A. BUILDING _____ B. WING _____	01/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCI-TRIANGLE HOUSE I	1406 TYONEK DRIVE DURHAM, NC 27703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 2 exercise to test the effectiveness of their current emergency plan.	E 039		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 2 of 4 audit clients (#2, #5) received a continuous active treatment plan consisting of needed interventions and services as identified in the individual program plan (IPP) in the area of adaptive equipment use. The findings are: 1. Client #2's adaptive equipment was not utilized as indicated in the IPP. During lunch observations at the day program on 1/14/19 at approximately 12:10pm, client #2 ate his lunch while utilizing a divided high side plate. Further observations at home on 1/14/19 client #2 ate his dinner utilizing a scoop plate and a bowl. Review on 1/15/19 of client #2's IPP dated 4/11/18 revealed, "adaptive equipment: scoop plate and bowl all meal."	W 249	All staff will receive training in: *ICF-IID Level of Care Basics:* • Active Treatment • Encouraging Independence • Teaching cues • Providing the least assistance necessary • Client #2's usage of adaptive dining equipment in all environments as outlined in the IPP (scoop plate and bowl) • Client #5 usage of adaptive dining equipment in all environments as outlined in the IPP (clothing protector). • All client's usage of adaptive • equipment in all environments as outlined in IPPs. The Director and Program Director will monitor at least 3 times a week and address any needed changes to provide needed assistance/training to assure IPP strategies are being implemented as outlined.	3-17-19

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G215	A. BUILDING _____ B. WING _____	01/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCI-TRIANGLE HOUSE I	1406 TYONEK DRIVE DURHAM, NC 27703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 3 Interview with the qualified intellectual disabilities professional (QIDP) on 1/15/19 revealed, client #2 should have utilized his scoop plate end bowl at all meal. She further acknowledged the IPP was not followed. 2. Client #5's adaptive equipment was not utilized as indicated in the IPP. During lunch observations at the day program on 1/14/19 at approximately 12:10pm, client #5 ate his lunch with paper towel tucked in the neck area. Client #5 was drooling while eating. Further observation at home on 1/15/19 during breakfast observations, the client ate his breakfast with no clothing protector. The client soiled his clothing and staff assisted him in changing after meal. Review on 1/15/19 of client #5's IPP dated 1/24/18 revealed, " adaptive equipment: adult napkin." Interview with QIDP on 1/15/19 revealed, Client #5 should have utilized his clothing protector during all meal. She further acknowledged the IPP was not followed.	W 249		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure a physician's orders were followed as written for 2 of 4 audit	W 368	In the future, client #1 will receive his "Sensodyne tooth paste" and all medications as ordered. All clients will receive all medications as ordered. All Medication Monitors will be re-trained in the SCI medication administration procedure 206-01 as well as the SCI procedure for medication errors 206-03. The Director will monitor medication administration at least once monthly, and the RN Team Lead will monitor at least quarterly.	3-17-19

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G215	A. BUILDING _____ B. WING _____	01/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCI-TRIANGLE HOUSE I	1406 TYONEK DRIVE DURHAM, NC 27703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 368	Continued From page 4 clients (#1,). The finding is: Physician's orders were not followed as indicated for client #1. During observations of medication administration in the home on 1/15/19 at 8:28am, staff administered 5 pills only to client #1. Review on 1/15/19 of client #1's physician's orders dated December 2018 revealed an order for, "Sensodyne tooth paste, use as directed once daily 8:00am." Interview on 1/15/19 with the medication technician revealed, client #1 routinely uses his toothpaste in the evening. Interview on 1/15/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the physician's order was not followed.	W 368		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Precautions were not taken to promote client/staff health/safety and prevent possible cross-contamination. During medication pass observations in the home on 1/14/19 at approximately 7:39pm, the staff poured unspecified amount of mouth rinse in a cup and headed to the bathroom with client #2. The staff deeped a swab in the liquid and handed	W 454	All personnel will receive training in: • infection control and the spread of infection for client #2 and all clients • Providing a sanitary environment • Glove usage • Precautions to promote client/staff health/safety, a healthy environment and prevent cross contamination The Program Director and / or the Director will monitor at least two times a week, with retraining and reminders provided as needed.	3-17-19

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G215	A. BUILDING _____ B. WING _____	01/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCI-TRIANGLE HOUSE I	1406 TYONEK DRIVE DURHAM, NC 27703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 454	Continued From page 5 it to the client. The client used it for his front teeth. The staff retrieved the swab from client hand and helped him brush his back teeth and all the four corners. After the rinsing, staff wiped her hand with her clothing. At no time did the staff wear gloves. During an interview on 1/14/19, the staff revealed gloves should be worn whilebrushing teeth or when there is potention of contamination and staff should have washed their hands before proceeding to another activity. During an interview on 1/15/19, the qualified intellectual disabilities professional (QIDP) revealed the staff should have worn the gloves while brushing client teeth.	W 454		